D H E C
PROMOTE PROTECT PROSPER

HEALTH HISTORY

If you do not know your family history, skip to Section 2.

Section 1: Family History

Check all the boxes that apply for parents, grandparents, brothers, sisters & children (living or dead).

- ☐ Blood clots legs/lungs/eyes (circle all that apply)
- ☐ High blood pressure/stroke
- ☐ High cholesterol
- ☐ Osteoporosis
- ☐ Diabetes (high blood sugar)
- ☐ Tuberculosis (TB) infection/disease
- ☐ Breast or Ovarian Cancer

Nurse's Comments:

Section 2: Personal Medical History

If you are here for yourself, check all the boxes that apply to you now or in the past. If you are here for your child, check all the boxes that apply to your child now or in the past.

- ☐ High blood pressure
- ☐ High blood pressure during pregnancy
- ☐ Stroke
- ☐ Blood clots legs/lungs/eyes (Circle all that apply)
- ☐ Migraine headaches
- ☐ Heart problems/heart disease
- ☐ High cholesterol
- ☐ Diabetes (high blood sugar)
- ☐ Diabetes (high blood sugar) during pregnancy
- ☐ Thyroid disease/goiter
- ☐ Gallbladder
- ☐ Stomach problems
- ☐ Liver problems
- ☐ Kidney problems
- ☐ Lung problems
- ☐ Tuberculosis (TB) infection/disease
- ☐ Cancer
- ☐ Breast problems
- ☐ Osteoporosis
- ☐ Surgery
- ☐ Seizures/convulsions (How often?) _____
- ☐ Mental health problems
- ☐ Birth defects
- ☐ Genetic problems
- ☐ Clotting disorders (free bleeder)
- ☐ Sickle cell anemia/trait
- ☐ Anemia (low blood or low iron)
- ☐ Sexually Transmitted Infections
  - ☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ HPV ☐ Syphilis
  - ☐ Trichomonas ☐ Other
- ☐ HIV/AIDS
- ☐ Hepatitis B Disease
- ☐ Hepatitis C Disease
- ☐ Hepatitis C Risks
  - ☐ Blood Transfusion/blood products prior to 1992
  - ☐ Received Clotting Factor before 1987
  - ☐ Used IV Drugs one or more times
  - ☐ Born to Woman with Hepatitis C
  - ☐ Organ Transplant before 1992
  - ☐ Long-term Hemodialysis
  - ☐ Long-term sex partner who is Hepatitis C positive
  - ☐ Lifetime Sex Partners ≥ 50

Do you have a healthcare provider? ☐ Yes ☐ No If yes, who?

Nurse's Comments:

Section 3: Reproductive Health

Men and Women: Please answer the following
Check the methods of birth control you use now or have used in the past.

- ☐ None
- ☐ Abstinence (no sex)
- ☐ Birth Control Pills
- ☐ Condoms
- ☐ Depo Provera shot
- ☐ Diaphragm
- ☐ IUD (Type: _____)
- ☐ Lunelle shot
- ☐ Natural FP/Cycle Beads/Rhythm
- ☐ Inplanon/Norplant
- ☐ Patch
- ☐ Ring
- ☐ Spermicide (foam, jelly, film)
- ☐ Sponge
- ☐ Sterilization (tubes tied or vasectomy)
- ☐ Withdrawal
- ☐ Other: _____

Nurse's Comments:

Client's ID Number: _____
Client's Name: _____ LABEL
Client's Date of Birth: _____

PLEASE TURN OVER AND COMPLETE SIDE 2.

Section 4: Health History For Women Only

Women: Please answer the following.

Age when period started: _____ Number of days you bleed when not on birth control: _____

How much do you bleed when you are not on birth control? ☐ Heavy ☐ Medium ☐ Light

Number of days between your period when not on birth control: _____

Age the first time you had vaginal sex: _____ Date of last pap smear: _____

Have you ever had a MMR shot (measles, mumps, rubella)? ☐ Yes ☐ No

Check the ones you have had: ☐ Infection in uterus/tubes ☐ Fibroid ☐ Endometriosis ☐ Abnormal Pap Smear ☐ Abnormal Mammogram

Did your mother take DES between 1940-1970? ☐ Yes ☐ No ☐ Unknown

Nurse's Comments

Women: List all Pregnancies including miscarriages and abortions.

Date Pregnancy Ended/Date of Birth	Birth Weight	Delivery	Problems
		☐ Vaginal ☐ C-Section	
		☐ Vaginal ☐ C-Section	
		☐ Vaginal ☐ C-Section	
		☐ Vaginal ☐ C-Section	
		☐ Vaginal ☐ C-Section	
		☐ Vaginal ☐ C-Section	
		☐ Vaginal ☐ C-Section	
		☐ Vaginal ☐ C-Section	

Section 5: Birth History for Children

FOR CHILDREN ONLY: Complete the following section if you are here for your child.

What did your child weigh at birth? | Were there problems at birth? ☐ Yes ☐ No

Nurse's Comments:

Patient Signature/Initials	Staff Signature/Initials	Date

Client's ID Number: _____
Client's Name: _____ LABEL
Client's Date of Birth: _____

SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL
Health History Form - DHEC 1859
(Instructions for Completing)
(6/2010)

Purpose: To provide a uniform system for collecting a health history to be used in the delivery of health services.

Explanation and Definition:

The form is to be used for patients receiving public health services and is adequate for more than one year of service. The extent of the information collected will depend on the patient and the reason for services. All items are to be completed in black ink. Refer to program guidelines to determine when this form is to be initiated and updated.

General Instructions for Use:

The Health History Form is to be completed by the patient or caregiver initially, then reviewed by the health professional. If the patient or caregiver is unable to complete the form, the health professional will complete it. In subsequent years, the health professional will review and update the form with the patient, per program guidelines.

The patient will complete the appropriate sections.

Adult men and women presenting for the first time should complete: Section 1: Family History; Section 2: Personal Medical History; and Section 3: Reproductive Health

Adult women should also complete Section 4: Health History for Women Only.

Children presenting for the first time should complete: Section 1: Family History; Section 2: Personal Medical History; and Section 5: Birth History for Children.

Upon completion of the form by the patient or caregiver, the health professional reviews the health history. Pertinent questions are asked to clarify the information provided. The health professional documents clarifying information on the form as needed.

In subsequent years, the form is reviewed and updated. Any item that is updated must be dated and initialed.

Note: **For family planning patients, the person providing the physical examination must be the professional reviewing the health history.**

Nurse's Comments:

Any additional comments/updates can be documented in "Nurse's Comments" of each section.

Patient Signature/Staff Signature/Date:

Initially, the patient signs the signature line indicating completion of the form. If the patient is unable to complete the form, draw a line through the patient signature line. The staff person reviewing the history (or completing the history if the patient is unable) signs their legal signature and initials and enters the month/day/year the health history was reviewed/updated.

In subsequent years, the staff person reviewing/updating the form signs, initials, and dates the form. If additions or changes are made to the form, the staff person initials the change(s). The patient doesn't have to sign the form in subsequent years.

Office Mechanics and Filing:

Refer to the most recent Comprehensive Health Records Manual for filing and disposition instructions.